The View from An Area Agency on Aging

A Presentation to the Chronic Care Model Advisory Committee to the Long Term Care Task Force

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What Is An "AAA"?

AREA **A**GENCY ON **A**GING

- Federally established in 1974 to focus on issues of the aging population
- Consumer-oriented, grassroots
- Local government, non-profit, or tribe
- Focus on needs of elders and people with disabilities, target to vulnerable people with chronic care needs and family caregivers
- In every community of the State and Nation: rural, suburban, and urban
- Collaborative, community-based, "can-do" culture

What Do AAA's Do?

- Community Assessment, Planning, Advocacy
- Chronic Care Management and Nurse Expertise
- Family Caregiver Support
- Caregiver and Provider Education and Training
- Manage Medicaid Home Care services through contracts with agencies and Individual Providers
- Fund and manage key senior services
- Coordinate with community partners and leverage community and grant funding

View from the AAA

- Washington State has built an exemplary long term care system
- Past successes mitigate current funding issues
- Many partnerships now established will yield positive results in the future
- The current community-based care system can make significant gains with additional support
- Local AAA pilots show success and models for good care and savings

Sample of Successful Services

Senior Programs -Senior Information & Assistance, helps people solve their own problems -Senior Nutrition, congregate and in-home, plus education -Medication education	**Chronic Care Mgt.** -COPES and MPC: 26,000+ -Efficient & effective case mgt and nurse expertise -Specialized approaches for different cultural groups -Pilots to improve outcomes
Family Caregiver Support -Respite In- and Out-of-Home -Adult Day Services -Caregiver Consultants -Caregiver Education	**Disability Prevention** -Programs promote physical activity, strength, & balance -Education about healthy practices

Partnerships = Success

- Community partnerships are critical to positive consumer outcomes
  - —Health care—Hospital communication and coordination; advocacy for health access; support for consumer education
  - —Knitting community services together: energy assistance, mental health, pharmacy, adult day service, dental, substance abuse services
  - —Public health—Wellness and prevention projects; pandemic flu preparedness for vulnerable adults

Examples of Current & Emerging Partnerships in Chronic Care Management

- Hospital—datasharing project with EMRs and consumer "shared care plan" for joint consumers in Whatcom County with St. Joseph Hospital
- RN Case Managers—coordination with health providers for access to meds, DME, intervention or follow-up
- Local Community Coalitions—assisting with access to health care, food, oral health care
- Local Brokers: transportation to medical appointments and arranging interpreter services
- Family Caregivers—Partnering to help caregivers in their work through education, consultation, support, and Respite

Multi-Dimensional, Integrated Services

- CARE assessment tool covers the breadth and depth of issues
- CM/RN coordinates care—personal care, training, DME, ancillary services, environmental modifications, nutrition referrals, PT & OT services
  - RN CM focuses on more clinically complicated cases and/or provides nurse consultation for Case Managers
  - Caseload ratio limits capacity of RNs in this role

Consumer-Centered

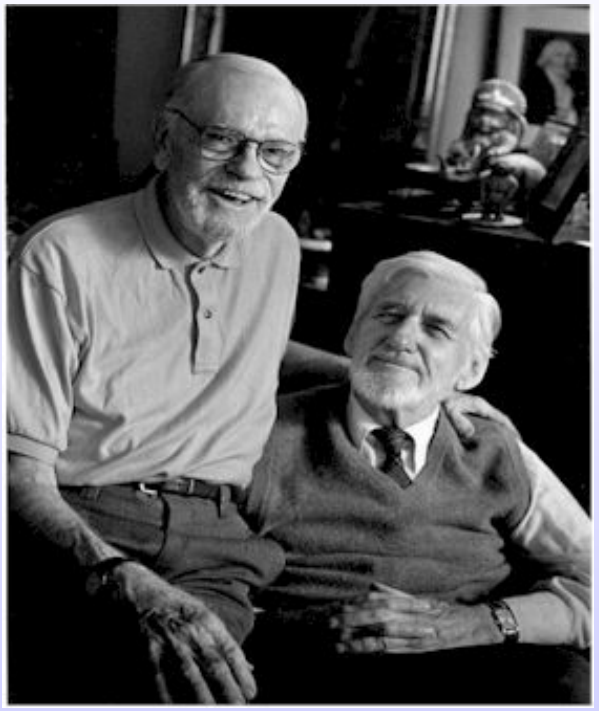
- Focus on consumer includes a "tool box" of standard as well as specialized supports
  - In-home care
  - Day Services
  - Nutrition
  - PEARLS
  - Tribal case aide
- Responsive to culture, language, and generational needs

Continuous Care

- Consumers assessed annually or as needed
- RN/CM provides problem-solving, education, and support between assessments
- Ongoing support for providers, including on-site teaching of skills and monitoring quality

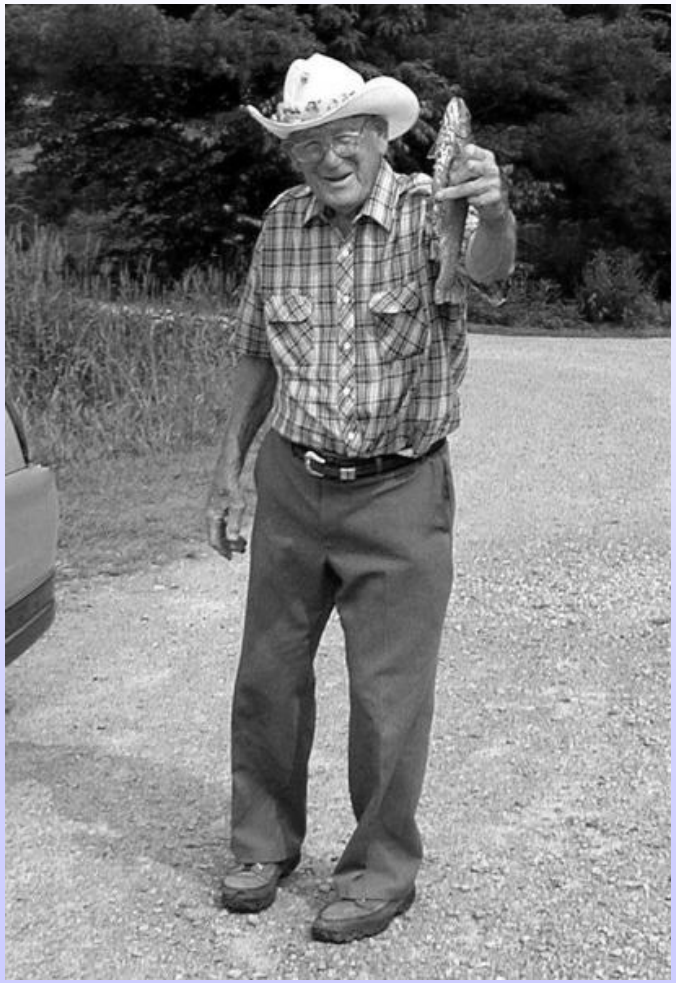
Focus on Functional Abilities

- Case Managers focus on functional abilities rather than just a disease
  - All aspects of the consumer's situation are evaluated
  - Chronic condition or disease guides planning, counseling, support and education for consumer and caregiver
  - Identified needs are matched with appropriate care intervention



"Management by Me"

- Consumers make choices for care
  - Personal Care: Individual or Agency
  - Choice of needed ancillary services
  - Follow through with a treatment or intervention, or not



Support for Informal Caregivers

- AAAs provide education, training, and support for informal caregivers
  - Basic and advanced training for necessary skills
  - Assistance with difficult personal care tasks
  - Burn-out prevention
  - Respite from their tasks

Options for Healthy Lifestyle Changes

- Training is used by consumers interested in making changes
  - Counseling
  - Medication Management
  - Nutrition Education
  - Physical Therapy
  - Occupational Therapy
- Opportunities exist for referrals to support the changes
  - Weight Training; walking programs; Tai Chi
  - Support Groups

Vision For Chronic Care Management Model

- Person-Centered
- Built on community strengths and systems
- Effective for diversity of our geography and demography, including rural and urban communities, different languages and cultures, different health care resources
- *AAA* pilots show success and a practical, cost-effective opportunity to improve care and achieve savings statewide